Anaphylaxis in Pregnancy 03/12

Data Collection Form - CASE

Please report all pregnant women diagnosed with anaphylaxis on or after 1st October 2012 and before 1st October 2015

Case Definition:

Anaphylaxis is defined as a severe, life-threatening generalised or systemic hypersensitivity reaction. The following three criteria must be met for a diagnosis of anaphylaxis to be made:

1. A life-threatening airway problem and/or breathing problem and/or circulatory problem
2. Sudden onset and rapid progression of symptoms
3. Skin and/or mucosal changes

However, skin and/or mucosal features in particular may not be evident if treatment is rapidly implemented, so please report all women in whom the final clinical diagnosis is anaphylaxis, irrespective of the presence or absence of skin/mucosal changes.

Please return the completed form to:
UKOSS
National Perinatal Epidemiology Unit
University of Oxford
Old Road Campus
Oxford
OX3 7LF
Fax: 01865 617775
Phone: 01865 289714

Case reported in: _______________
Instructions

1. Please do not enter any personally identifiable information (e.g. name, address or hospital number) on this form.
2. Please record the ID number from the front of this form against the woman’s name on the Clinician’s Section of the blue card retained in the UKOSS folder.
3. Fill in the form using the information available in the woman’s case notes.
4. Tick the boxes as appropriate. If you require any additional space to answer a question please use the space provided in section 7.
5. Please complete all dates in the format DD/MM/YY, and all times using the 24hr clock e.g. 18.37
6. If codes or examples are required, some lists (not exhaustive) are included on the back page of the form.
7. If the woman has not yet delivered, please complete the form as far as you are able, excluding delivery and outcome information, and return to the UKOSS Administrator. We will send these sections again for you to complete two weeks after the woman’s expected date of delivery.
8. If you do not know the answers to some questions, please indicate this in section 7.
9. If you encounter any problems with completing the form please contact the UKOSS Administrator or use the space in section 7 to describe the problem.

Section 1: Woman’s details

<table>
<thead>
<tr>
<th>1.1 Year of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>1.2 Ethnic group* (enter code, please see back cover for guidance)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>1.3 Marital status</th>
</tr>
</thead>
<tbody>
<tr>
<td>single</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1.4 Was the woman in paid employment at booking?</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Yes, what is her occupation</td>
</tr>
<tr>
<td>If No, what is her partner’s (if any) occupation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1.5 Height at booking</th>
</tr>
</thead>
<tbody>
<tr>
<td>cm</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1.6 Weight at booking</th>
</tr>
</thead>
<tbody>
<tr>
<td>kg</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1.7 Smoking status</th>
</tr>
</thead>
<tbody>
<tr>
<td>never</td>
</tr>
</tbody>
</table>

Section 2: Previous Obstetric History

<table>
<thead>
<tr>
<th>2.1 Gravidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of previous completed pregnancies beyond 24 weeks</td>
</tr>
<tr>
<td>Number of previous pregnancies less than 24 weeks</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.2 Did the woman have any previous pregnancy problems?*</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Yes, please specify</td>
</tr>
</tbody>
</table>

Section 3: Previous Medical History

<table>
<thead>
<tr>
<th>3.1 Does the woman have a previous history of anaphylaxis?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.2 Does the woman have a previous history of atopy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Yes, please tick all that apply</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.3 Does the woman have a history of allergic reaction to any of the following?</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Yes, please tick all that apply</td>
</tr>
<tr>
<td>Dust mites</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>If Other, please specify</th>
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</thead>
</table>

*For guidance please see back cover
### Section 4a: This Pregnancy

#### 4a.1 Final Estimated Date of Delivery (EDD)**

<p>| | | | | |</p>
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<th></th>
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</thead>
</table>

#### 4a.2 Was this pregnancy a multiple pregnancy?

- [ ] Yes
- [ ] No

If Yes, specify number of fetuses

#### 4a.3 Were there any other problems in this pregnancy?

- [ ] Yes
- [ ] No

If Yes, please specify

### Section 4b: Diagnosis and management of anaphylaxis

#### 4b.1 What was the date and time when symptoms were first experienced?

<p>| | | | | |</p>
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</thead>
</table>

#### 4b.2 What was the date and time anaphylaxis was diagnosed?

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</table>

#### 4b.3 Did the woman have a life threatening airway problem?

- [ ] Yes
- [ ] No

If Yes, please tick all that apply

- Laryngeal or pharyngeal oedema
- Hoarse voice
- Stridor
- Other

If Other, please specify

#### 4b.4 Did the woman have a life threatening breathing problem?

- [ ] Yes
- [ ] No

If Yes, please tick all that apply

- Shortness of breath and raised respiratory rate
- Wheeze
- Decreased oxygen saturations
- Confusion secondary to hypoxia
- Cyanosis
- Respiratory exhaustion or respiratory arrest
- Other

If Other, please specify

#### 4b.5 Did the woman have a life threatening circulatory problem?

- [ ] Yes
- [ ] No

If Yes, please tick all that apply

- Signs of shock such as faintness, pallor or clammy skin
- Tachycardia >100bpm
- Systolic BP <90mmHg
- Decreasing level of consciousness
- Signs of ischaemia on ECG
- Cardiac arrest

#### 4b.6 Did the woman have skin or mucosal changes (for example flushing, urticarial/nettle rash, angioedema)?

- [ ] Yes
- [ ] No

If Yes, please give details

#### 4b.7 Where was the woman when anaphylaxis occurred?

- Home or Community
- Postnatal ward
- Delivery suite
- Theatre
- Other

#### 4b.8 Was there a suspected causative agent?

- [ ] Yes
- [ ] No
- Unknown

If Yes, please state the suspected causative agent:

#### 4b.9 Did the woman have any known previous exposure to the causative agent?

- [ ] Yes
- [ ] No
- Unknown

If Yes, please state when

---

*For guidance please see back cover*
**4b.10** Were any regular medications (including over the counter, herbal or recreational) being taken prior to the onset of anaphylaxis?  
Yes [ ]  No [ ]  
If Yes, please list these medications ________________________________

**4b.11** Were vital observations recorded prior to anaphylaxis?  
Yes [ ]  No [ ]  
If Yes, what were the most recent set of vital observations prior to the diagnosis of anaphylaxis

<table>
<thead>
<tr>
<th>Observation</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure (mmHg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen saturation (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart rate (bpm)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory rate/min</td>
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<td></td>
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</tbody>
</table>

**4b.12** Were vital observations recorded at the time of diagnosis of anaphylaxis?  
Yes [ ]  No [ ]  

<table>
<thead>
<tr>
<th>Observation</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure (mmHg)</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory rate/min</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**4b.13** Did the woman have a cardiorespiratory arrest?  
Yes [ ]  No [ ]  
If Yes, please state the date and time at which this occurred D M Y YMD: h m mh

**4b.14** Was any fetal heart rate abnormality noted?  
Yes [ ]  No [ ]  
If Yes,  
What was the abnormal rhythm?  
Date and time it was first noted D M Y YMD: h m mh  
How long did it persist?  minutes

**4b.15** After symptoms were first experienced, was high flow oxygen given?  
Yes [ ]  No [ ]

**4b.16** After symptoms were first experienced, were IV fluids given?  
Yes [ ]  No [ ]  
If Yes, please state

<table>
<thead>
<tr>
<th>Name of fluid</th>
<th>Volume (ml)</th>
<th>Time started</th>
<th>Time stopped</th>
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</table>

**4b.17** After symptoms were first experienced, were any of the following drugs administered?  
Yes [ ]  No [ ]  
If Yes,  

<table>
<thead>
<tr>
<th>Name of drug</th>
<th>Time given</th>
<th>Dose given</th>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adrenaline</td>
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<td></td>
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<tr>
<td>Chlorphenamine</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Hydrocortisone</td>
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</tbody>
</table>

*For guidance please see back cover*
4b.18 Were any other drugs given during the resuscitation period?
   Yes ☐ No ☐
   If Yes, please state:

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Time given</th>
<th>Dose given (Include units)</th>
<th>Route</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
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4b.19 Once resuscitation was complete, was blood taken for serum tryptase levels?
   Yes ☐ No ☐
   If Yes, please state the result:

   Normal ☐ Raised ☐

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Section 5: Delivery

5.1 Did this woman have a miscarriage?
   Yes ☐ No ☐
   If Yes, please specify date

5.2 Did this woman have a termination of pregnancy?
   Yes ☐ No ☐
   If Yes, please specify date

5.3 Is this woman still undelivered?
   Yes ☐ No ☐
   If Yes, will the woman receive the remainder of her antenatal care at your hospital?
   Yes ☐ No ☐
   If No, please indicate the name of the hospital providing future care

   Will she be delivered at your hospital?
   Yes ☐ No ☐
   If No, please indicate the name of delivery hospital

5.4 Was delivery induced?
   Yes ☐ No ☐
   If Yes, please state indication
   If Yes, was vaginal prostaglandin used?
   Yes ☐ No ☐

5.5 Did the woman labour?
   Yes ☐ No ☐
   If Yes, what date and time was labour diagnosed?
   If Yes, was syntocinon used?
   Yes ☐ No ☐
   Did the woman have an epidural for analgesia?
   Yes ☐ No ☐

5.6 Was delivery by caesarean section?
   Yes ☐ No ☐
   If Yes, please state:
   Grade of urgency
   Indication for caesarean section
   Method of anaesthesia:
   Spinal ☐ Epidural top-up ☐ CSE ☐ Epidural ☐ General anaesthetic ☐
   The time between decision and delivery of the baby

*For guidance please see back cover
Section 6: Outcomes

Section 6a: Woman

6a.1 Was the woman admitted to ITU (critical care level 3)?

Yes ☐ No ☐

If Yes, please specify:

Duration of stay ☐ days

Or Tick if woman is still in ITU

Or Tick if woman was transferred to another hospital

6a.2 Did any other major maternal morbidity occur?*

Yes ☐ No ☐

If Yes, please specify ________________________________

6a.3 Did the woman die?

Yes ☐ No ☐

If Yes, please specify date and time of death D M Y YMD h m

What was the primary cause of death as stated on the death certificate?

(Please state if not known) ________________________________

Section 6b: Infant

NB: If more than one infant, for each additional infant, please photocopy the infant section of the form (before filling it in) and attach extra sheet(s) or download additional forms from the website: www.npeu.ox.ac.uk/ukoss

6b.1 Date and time of delivery D M Y YMD h m

6b.2 Mode of delivery

Spontaneous vaginal ☐ Ventouse ☐ Lift-out forceps ☐ Rotational forceps ☐

Breech ☐ Pre-labour caesarean section ☐ Caesarean section after onset of labour ☐

6b.3 Birthweight g

6b.4 Sex of infant Male ☐ Female ☐ Indeterminate ☐

6b.5 Was the infant stillborn?

Yes ☐ No ☐

If Yes, was the death ante-partum or intra-partum? Ante-partum ☐ Intra-partum ☐

6b.6 Apgar 5 min ☐ 10 min ☐

6b.7 Did the infant require resuscitation at birth?

Yes ☐ No ☐

6b.8 Were cord gases measured?

Yes ☐ No ☐

If Yes, please record cord gas results:

<table>
<thead>
<tr>
<th>Arterial</th>
<th>Venous</th>
</tr>
</thead>
<tbody>
<tr>
<td>pH</td>
<td></td>
</tr>
<tr>
<td>Base Excess</td>
<td>-</td>
</tr>
</tbody>
</table>

6b.9 Did the infant experience any seizures?

Yes ☐ No ☐ Unknown ☐

6b.10 Was an aEEG or a full EEG performed?

Yes ☐ No ☐ Unknown ☐

If Yes, please state the results ________________________________

6b.11 Did the infant have any neurological imaging?

Yes ☐ No ☐ Unknown ☐

If Yes, type of imaging used ________________________________

Date and time D M Y YMD h m

What damage was identified? ________________________________

*For guidance please see back cover
6b.12 Did this infant have a neurological examination?  
- Yes ☐  No ☐  Unknown ☐
  If Yes, was there any evidence of neurological deficit on neurological examination?  
    - Yes ☐  No ☐
  If Yes, please state what this was ___________________________

6b.13 Was the infant admitted to the neonatal unit?  
- Yes ☐  No ☐
  If Yes, please state the duration of stay ☐ days
  Or Tick if the infant is still in the neonatal unit ☐
  Or Tick if the infant was transferred to another hospital ☐

6b.14 Was a diagnosis of neonatal encephalopathy made?  
- Yes ☐  No ☐  Unknown ☐
  If Yes, was the baby cooled?  
    - Yes ☐  No ☐  Unknown ☐

6b.15 Did any other major infant complications occur?*  
- Yes ☐  No ☐
  If Yes, please specify details ___________________________

6b.16 Did this infant die?  
- Yes ☐  No ☐
  If Yes, please specify date of death ☐ ☐ ☐ ☐
  What was the primary cause of death as stated on the death certificate?  
  (Please state if not known) ___________________________

Section 7:
Please use this space to enter any other information you feel may be important
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Section 8:
Name of person completing the form ___________________________
Designation ___________________________
Today's date ☐ ☐ ☐ ☐

You may find it useful in the case of queries to keep a copy of this form.

*For guidance please see back cover
Definitions

1. UK Census Coding for ethnic group

WHITE
  01. British
  02. Irish
  03. Any other white background

MIXED
  04. White and black Caribbean
  05. White and black African
  06. White and Asian
  07. Any other mixed background

ASIAN OR ASIAN BRITISH
  08. Indian
  09. Pakistani
  10. Bangladeshi
  11. Any other Asian background

BLACK OR BLACK BRITISH
  12. Caribbean
  13. African
  14. Any other black background

ASIAN OR ASIAN BRITISH
  15. Chinese
  16. Any other ethnic group

2. Previous or current pregnancy problems, including:

Thrombotic event
Amniotic fluid embolism
Eclampsia
3 or more miscarriages
Preterm birth or mid trimester loss
Neonatal death
Stillbirth
Baby with a major congenital abnormality
Small for gestational age (SGA) infant
Large for gestational age (LGA) infant
Infant requiring intensive care
Puerperal psychosis
Placenta praevia
Gestational diabetes
Significant placental abruption
Post-partum haemorrhage requiring transfusion
Surgical procedure in pregnancy
Hyperemesis requiring admission
Dehydration requiring admission
Ovarian hyperstimulation syndrome
Severe infection e.g. pyelonephritis

3. Previous or pre-existing maternal medical problems, including:

Cardiac disease (congenital or acquired)
Renal disease
Endocrine disorders e.g. hypo or hyperthyroidism
Psychiatric disorders
Haematological disorders e.g. sickle cell disease, diagnosed thrombophilia
Inflammatory disorders e.g. inflammatory bowel disease
Autoimmune diseases
Cancer
HIV

4. Estimated date of delivery (EDD):

Use the best estimate (ultrasound scan or date of last menstrual period) based on a 40 week gestation

5. RCA/RCOG/CEMACH/CNST Classification for urgency of caesarean section:

1. Immediate threat to life of woman or fetus
2. Maternal or fetal compromise which is not immediately life-threatening
3. Needing early delivery but no maternal or fetal compromise
4. At a time to suit the woman and maternity team

6. Major maternal morbidity, including:

Persistent vegetative state
Cardiac arrest
Cerebrovascular accident
Adult respiratory distress syndrome
Disseminated intravascular coagulopathy
HELLP
Pulmonary oedema
Mendelson’s syndrome
Renal failure
Thrombotic event
Septicaemia
Required ventilation

7. Fetal/infant complications, including:

Respiratory distress syndrome
Intraventricular haemorrhage
Necrotising enterocolitis
Neonatal encephalopathy
Chronic lung disease
Severe jaundice requiring phototherapy
Major congenital anomaly
Severe infection e.g. septicaemia, meningitis
Exchange transfusion

Version 3, April 2014